STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

February 13, 2009

GENERAL LETTER NO. 8-B-65

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter B, ***APPLICATION PROCESSING***, Contents (page 1), revised; pages 3, 4, 4a, 4b, 10, 10a, 17, and 18, revised.

Summary

This chapter is revised to:

- Clarify that the *Health and Financial Support Application* may be used for all Medicaid coverage groups, including State Supplementary Assistance.
- Reference Chapter 8-O, ***IOWACARE***, for applications that may be used for IowaCare.
- Clarify "Restricting Months of Beginning Eligibility for MEPD" to state that an applicant may choose between MEPD and Medically Needy for "back months" before the date the MEPD approval was entered on the Automated Benefit Calculation system.
- Delete the requirement to contact the Disability Determination Services claim examiner to track a disability referral.
- Clarify that there is not any retroactive eligibility for qualified Medicare beneficiary coverage and that IowaCare has only one month of retroactive eligibility.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter B, and destroy them.

Page	Date
Contents (page 1)	February 1, 2008
3	February 1, 2008
4	July 27, 2007
4a, 4b	October 17, 2008
10, 10a	February 1, 2008
17, 18	February 3, 2006

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Application Form	Who Should Use the Form
Health and Financial Support Application, forms 470-0462 and 470-0466 (Spanish)	People applying for FIP or Food Assistance **and** the following Medicaid coverage groups: ♦ FMAP-related coverage groups, ♦ FMAP-related Medically Needy ♦ Refugee Medical Assistance, ♦ Iowa Family Planning Network (IFPN) ♦ SSI-related coverage group ♦ SSI-related Medically Needy ♦ State Supplementary Assistance
hawk-i *Application* (Comm. 156) or ***hawk-i*** *Electronic Application Summary and Signature Page*, form 470-4016	When an application is made for the ***hawk-i*** program

Include form 470-2826, *Supplemental Insurance Questionnaire*, in the application packet for all new applications, except for clients approved for SSI. Have the applicant complete form 470-2826 if insurance availability is indicated on the application or you are aware that the applicant has insurance available. **Exceptions:**

- Clients, who complete form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), *SSI Medicaid Information*, do not have to complete form 470-2826. Clients approved for SSI must complete the insurance section of form 470-2304, 470-2304(S), 470-0364, or 470-0364(S) before Medicaid can be approved, unless you already have all the information needed.
- Clients who have received Medicaid within the last six calendar months do not have to complete form 470-2826 unless there has been a change in medical resources since the person last received assistance. Verify any changes and ask the client to complete the *Supplemental Insurance Questionnaire*, if necessary.
- Applicants for the IFPN coverage group do not have to complete form 470-2826.

See 6-Appendix for instructions about what to do with the *Supplemental Insurance Questionnaire* and the information provided on the form.

See 8-O, Applications, for the applications that may be used for persons applying for IowaCare.

Referrals From the *hawk-i* Program

Legal reference: 441 IAC 86.3(514I)

When a ***hawk-i*** *Application* (Comm. 156) or ***hawk-i*** *Electronic Application Summary and Signature Page* (form 470-4016) is filed with the ***hawk-i*** administrator, the application is screened to determine if the child may qualify for Medicaid.

If it appears that Medicaid eligibility exists, ***hawk-i*** staff give the original application and copies of accompanying verification documents to income maintenance workers located at the ***hawk-i*** office for a Medicaid eligibility determination for the children. (A ***hawk-i*** application is considered a Medicaid application for the children only.) The ***hawk-i*** administrator also:

- Notifies the family of the referral.
- Returns any original verification documents.

If the children's application is pending with the income maintenance worker at the ***hawk-i*** office when the parents request Medicaid for themselves, the parents' application date is **initially** set the **same** as the children's application date.

The income maintenance worker at the ***hawk-i*** office documents the contact date and sends the parents form 470-2927 or 470-2927(S), *Health Services Application,* to be completed and returned to the local office.

If the income maintenance worker at the ***hawk-i*** office approves the children for Medicaid and the parents are eligible for Family Medical Assistance Program (FMAP), Child Medical Assistance Program (CMAP), or Mothers and Children (MAC), add the parents to the children's case without a Medicaid application. The effective date for the parents is the same as for the children.

If the income maintenance worker at the ***hawk-i*** office approves the children for Medicaid and the parents are eligible only for Medically Needy, the paper application is required. The Medically Needy application date is the date the local office receives the *Health Services Application.*

If the income maintenance worker at the ***hawk-i*** office denies the children's application, the parents' *Health Services Application* is also a reapplication for the children. The date of application is the date the local office receives the *Health Services Application.*

If the parents contact the local office to request Medicaid for themselves while the children's Medicaid application is pending with the worker at the ***hawk-i*** office, the date the local office receives the paper application is the application date for adding the parents to the children's eligible group.

If the parents request Medicaid after the children are approved for Medicaid, the local office income maintenance worker handles the request. All policies regarding application processing for Medicaid apply. These include, but are not limited to, time frames for processing the application and notice and verification requirements.

Who Must Sign the Application

Legal reference: 42 CFR 435.907 and 435.909; 441 IAC 76.1(249A), 76.1(2)

To be considered a valid application, an application must have the following:

- A legible name,
- An address, and
- A signature.

Before eligibility can be **approved**, all application forms must be signed by one of the following:

- The applicant (including a child living independently or a minor applicant for the Iowa Family Planning Network), or
- A child's parent or stepparent in the home who is not prevented from acting on behalf of the child, or
- A spouse, or
- A guardian or conservator, or
- Someone acting on behalf of the applicant, or
- A responsible person acting on behalf of a minor or of an incompetent, physically incapacitated, or deceased person. This includes a person or organization that has signed form 470-3356, *Inability to Find a Responsible Person*. See REPRESENTATION in this chapter.

Note: If the applicant is under a guardianship or conservatorship that was established voluntarily, the applicant may sign the application. When a person voluntarily asks the court to appoint a guardian or conservator, the court may do so without making a determination that the person is incompetent.

Applications that are filed electronically, whether signed and faxed or scanned and e-mailed, do not have to be signed again.

Where the Application Must Be Filed

Legal reference: 441 IAC 76.1(1), 76.1(3), 86.3(3)

The application forms listed under Which Application Form to Use may be filed in one of the following locations:

- At a Department office (whether open full time or less than full time).
- At a disproportionate-share hospital, federally qualified health center, mental health institute, state resource center, or other facility where out-stationing activities are provided.
- With the third-party administrator for the ***hawk-i*** program.

Form 470-2927 or 470-2927(S), *Health Services Application*, can also be filed at:

- Offices of a qualified provider of presumptive Medicaid eligibility.
- WIC sites.
- Maternal or child health centers.

If you receive an application that should have been filed in another DHS office, send the application to the correct office for processing within two working days of receipt.

Responsibility for processing waiver service applications and applications from persons living in institutions lies with the county indicated on the following chart. **Exceptions:**

- If the county where the client lives, the county of legal settlement, or the county where the facility is located has a less-than-full-time office, the application is processed at the full-time Department office associated with that county.
- If an income maintenance worker is out-stationed at a facility, that worker processes the application, regardless of the applicant's county of residence.

Concurrent Medicaid and Social Security Disability Determinations

Legal reference: 42 CFR 435.909 and 435.541, 441 IAC 75.20 (2)"b" and "c"

Pend the Medicaid application and wait for the Social Security Administration disability decision if:

- An initial Social Security disability decision (for either SSI or SSDI) is pending when the Medicaid application is filed, or
- The person applies for or intends to apply for SSDI or SSI benefits within ten working days of the Medicaid application.

If either of those situations exists:

1. Send form 470-2631, *Notice of Pending Medicaid Application*, to the Social Security Administration as a notice that this person has applied for Medicaid.
2. Send a copy of the *Notice of Pending Medicaid Application* to Disability Determination Services (DDS) to notify that agency of the pending application.
3. If the applicant is eligible for Medically Needy, see 8-J, SSI-Related Medically Needy.

DDS completes Section II of the form, giving the status of the disability determination, and returns the form within 15 days.

- If DDS does not have a referral from the Social Security Administration, find out why.
- If DDS completed a disability determination for the Social Security Administration on an SSI recipient, check the SDX screen to determine SSI status, and approve or deny as appropriate.
- If DDS completed a disability determination for Social Security disability benefits, wait for the Social Security decision.
- If a disability determination is pending with DDS, make a note in the narrative.
- If DDS made a disability decision, contact the Social Security Administration to see if a full eligibility decision will be made within 30 days.
    - If so, wait for the Social Security decision.

- If a full eligibility decision will not be made in 30 days, get a copy of the disability determination from Social Security and get the necessary income and resource verification from the applicant. Complete the Medicaid application processing.

♦ When a final disability decision is made, contact the Social Security Administration to see if the full eligibility determination will be completed in ten days.

- If so, wait for the Social Security Administration decision.
- If the eligibility decision will not be determined in ten days, get a copy of the Social Security disability decision and determine Medicaid eligibility.

INTERVIEWS

Legal reference: 42 CFR 435.905-435.914; 441 IAC 76.2(1), 76.1(3)

An interview is not required when determining Medicaid eligibility for an FMAP-related or SSI-related applicant or member unless you determine that an interview is necessary to:

♦ Clarify information on the application,
♦ Clarify questionable information, or
♦ Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the "prudent person concept." See 8-A, Definitions, for "prudent person concept."

2. Mr. B files for SSI on January 15. SSI cash payments are approved effective March 1. In order for SSI payments to begin effective March 1, the Social Security Administration must have determined that Mr. B met all SSI eligibility criteria for the month of February.

   Mr. B did not meet all eligibility criteria for the month of January (or SSI would have begun February 1). It is not necessary to verify information independently for the month of February. It is necessary to verify information and determine the reason that Mr. B was ineligible for January.

Use the SSI application date as the Medicaid application date. The effective date of eligibility can be no earlier than three months before the date of application for SSI. This date is on the SDX. When the date of the SSI application is in a different month from the month that SSI eligibility begins, determine if there is Medicaid eligibility for:

- The month of SSI application.
- All months between the date of application and the month of eligibility for SSI.
- The retroactive period.

See Collecting Eligibility Information From SSI Recipients.

Restricting Months of Beginning Eligibility for MEPD

When a disability determination needs to be completed, it may take three or more months to get a decision on disability. At the time of approval, there may be more than two months from the date the case is eligible (positive date entered on ABC) until the date the case is actually approved on ABC. The months before the month when the case is actually approved on ABC back to the positive date month are referred to as "back months."

The client may not want MEPD coverage for all of the "back months," so may not want premium payments applied to those months. The client may chose between MEPD and Medically Needy Coverage. See 8-F, Relationship to Medically Needy.

Because payments are applied in a specified order, the months the client does not want to pay must be "blocked" on the billing system so that payments are not applied to them. Have the client provide a signed statement that identifies the back months the client does not want covered before actually blocking the months.

Use the MEPC screen to "block" a month so that payments will not be applied. See 14-B(9), Change to MEPD Premium: Using MEPC.

If a premium has already been applied for any back months, then you are **not** allowed to block the month, as eligibility was granted and a medical card issued. If a premium for a back month has not been paid, then you may block the month.

If you do block a month where the premium has already been applied, the system will "back out" the payment and send you an e-mail message to let you know that a recoupment needs to be completed.

If a month is blocked in error, the month may be unblocked on MEPC by entering a "U" over the "B" on the month line.

DETERMINING ELIGIBILITY FOR THE RETROACTIVE PERIOD

Legal reference: 42 CFR 435.914, 441 IAC 76.5(1)

Medicaid benefits are available for any or all of the three months before the month in which the application is filed. This time is called the "retroactive period." **Exception:** The following coverage groups do not have retroactively eligibility:

- The Iowa Family Planning Network (IFPN), and
- The qualified Medicare beneficiary (QMB).

An IowaCare member may be eligible for only one retroactive month.

To be eligible for retroactive benefits, the person must meet both of the following:

- The person has paid or unpaid medical bills for Medicaid-covered services received during the retroactive period, and
- The person would have been eligible for Medicaid benefits in the months services were received, if an application had been filed.

An applicant does not need to be eligible in the month of application to be eligible for the retroactive period. If an application is submitted on behalf of a deceased person, determine the deceased person's retroactive eligibility using the same requirements.